AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Revcovi™ (elapegademase-lvlr) **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Dosing Limit:

A. Quantity Limit (max daily dose): Pharmacy Benefit - 2.4 mg/1.5 mL single dose vial: 20 vials per 7 days

B. Max Units (per dose and over time): Medical Benefit (J3590) - 23 mg twice weekly

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization Approval: 12 months

- **Coverage is provided in the following conditions:**
  - ❑ Must not be used in combination with pegademase-bovine

AND

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- ❑ Member has severe combined immunodeficiency disease (SCID) with a definitive diagnosis of adenosine deaminase deficiency as determined by one of the following:
  - ❑ Deficient ADA catalytic activity (<1% of normal) in hemolysates (in untransfused individuals) or in extracts of other cells (e.g., blood mononuclear cells, fibroblasts)

OR

  - ❑ Detection of pathogenic mutations in the ADA gene by molecular genetic testing;

AND

- ❑ Member has a marked elevation of the metabolite dATP or total dAdo nucleotides (the sum of dAMP, dADP and dATP) in erythrocytes;

AND

- ❑ Member is not a candidate for or has failed hematopoietic cell transplantation (HCT);

AND

- ❑ Member does not have severe thrombocytopenia (<50,000/microL);

AND

- ❑ Baseline lab values for plasma ADA activity, red blood cell deoxyadenosine triphosphate (dATP), trough deoxyadenosine nucleotide (dAXP) levels and/or total lymphocyte counts must be submitted with this request
- ❑ Is the member transitioning from Adagen® to Revcovi™? ❑ Yes ❑ No
- ❑ Member's current height and weight must be noted and dosing will be based on ideal body weight

  Height: _____ Weight: _____

Reauthorization of Therapy: Yearly reauthorization is required for continuation of therapy. (12 month approval). Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- **Authorizations can be renewed based on the following criteria:**
  - ❑ Member continues to meet the criteria identified in Initial Approval Section.

AND

  - ❑ Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe injection site reactions (e.g., bleeding), severe thrombocytopenia, etc.;

AND

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- ❑ Adequate documentation of disease stability and/or improvement as indicated by one or more of the following must be submitted:
  - ❑ Increase in plasma ADA activity (target trough level ≥ 15 mmol/hr/L)
  - ❑ Red blood cell dATP level decreased (target ≤ 0.005 to 0.015 mmol/L)
  - ❑ Improvement in immune function with diminished frequency/complications of infection as evidenced in improvement in the ability to produce antibodies
  - ❑ Improvement in red blood cell dAXP levels (target trough level ≤ 0.02 mmol/L)
- ❑ Member's current height and weight must be noted and dosing will be based on ideal body weight

  Height: _____ Weight: _____

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*